STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	C 02/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF PIKEVILLE	260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey (KY15745, KY15747, KY15875) was conducted on February 9-11, 2011. KY15745 was substantiated. KY15747 and KY15875 were unsubstantiated. Deficiencies were cited with the highest scope and severity being at "D" level.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	Signature Health Care of Pikeville does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should considered as a waiver of any potentially applicable Peer Review, Quality assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elvis Jones	Administrator	3/4/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to notify the resident's legal representative of a need to alter treatment for one of three residents (resident #2). Resident #2 refused to go to a scheduled dialysis treatment on December 9, 2010, and the facility failed to notify the resident's legal representative of the refusal. The findings include: Review of resident #2's medical record revealed the resident received dialysis three times a week and the dialysis treatments were scheduled on Tuesday, Thursday, and Saturday. Review of resident #2's nurse's notes revealed the resident went to dialysis on Tuesday, December 7, 2010, Friday, December 10, 2010, and Saturday, December 11, 2010. There was no documentation in the nurse's notes on Thursday, December 9, 2010, as to why resident #2 did not receive the normally scheduled dialysis treatment. There was no documentation in the nurse's notes that resident #2's legal representative was notified the resident did not receive the scheduled dialysis treatment on December 9, 2010. Review of the facility's Change in Condition Action/Notification policy dated December 2010 revealed the facility staff was responsible to notify the resident's legal representative when a need to alter treatment or a resident's refusal of compliance with the prescribed plan of care occurred.	F 157	F157 483.10(b)(11) NOTIFICATION OF CHANGES **Corrective Action for Resident(s) Affected:** The facility reviewed medical record for resident #2. The D.O.N. spoke with resident #2's family and updated them on all aspects of her care. **How the facility will act to protect residents in similar situations:** All residents who receive dialysis medical record will be reviewed going back to December 1, 2010 to ensure that the family was notified for any refusal of dialysis by March 5, 2011. **Measures to prevent reoccurrence:** All physician orders will be reviewed in the daily clinical meeting held Monday through Friday as well as 24 hour report to ensure that the family was notified of any change in condition. All weekend orders will be reviewed on Mondays in the clinical meeting. The DON/Staff Development Coordinator will in-service all nurses on the facility policy for family notification for any refusal of treatment or any change in condition and documenting that notification. Any resident who refuses treatment or has a change in condition will be reviewed in the morning clinical meeting held Monday through Friday to ensure family has been notified with any change in condition. **Monitoring of Corrective Action:** The findings from the clinical meeting review of family notification for a resident's change in condition will be reviewed by the Quality Assurance Committee monthly for 6 months, for recommendations and further follow-up as indicated **Completion date: 3/18/11**	

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F 157	Continued From page 2 An interview conducted on February 10, 2011, at 2:45 p.m., with the Clinical Manager at the Dialysis Clinic confirmed resident #2 did not receive a dialysis treatment on December 9, 2010, but made up the treatment on December 10, 2010. The Clinical Manager stated resident #2 had occasionally refused dialysis treatments and the clinic would inform the resident's legal representative and the legal representative would speak to the resident and the resident would then allow the dialysis treatment. An interview conducted on February 10, 2011, at 12:40 p.m., with the Director of Nursing (DON) revealed no documentation in resident #2's medical record about the resident not receiving the dialysis treatment on December 9, 2010. There was no documentation the facility staff notified resident #2's legal representative that the dialysis treatment was not received on December 9, 2010.	F 157		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to accommodate the needs of one of six sampled	F 246		

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F 246	Continued From page 3 residents. Resident #5 has been unable to get up out of bed after receiving a shower related to the facility not having enough slings for the mechanical lift. Resident #5 was unable to access the call light while the resident was on the telephone. The findings include: A review of the medical record for resident #5 revealed the resident was admitted to the facility on October 20, 2009, with diagnoses including Progressive Multiple Sclerosis with Quadriplegia, Gastroesophageal Reflux Disease, and Depression. A review of the Minimal Data Set (MDS) quarterly assessment dated January 18, 2011, revealed the resident required total assistance of two staff persons with transfers and the resident utilized a wheelchair for locomotion. A review of the comprehensive care plan for resident #5 revealed the resident had been assessed to require a mechanical lift for transfers and to require adaptive equipment to access the telephone and the nurse call light. Observation of resident #5 on February 9, 2011, at 1:45 p.m., revealed the resident was in bed with a telephone headset on. The call light was hanging over the bedrail on the right side of the bed and was not within the resident's reach. An interview conducted with resident #5 on February 9, 2011, at 1:50 p.m., revealed the resident stated he/she was only able to move his/her head and neck. The resident further voiced being unable to get up into a chair on the	F 246	**F246 483.15(e)(1)REASONABLE ACCOMMODATION OF NEEDS/ PREFERENCES** **Corrective Action for Resident(s) Affected:** The facility ordered 10 slings on 2/11/11. A breathe call cord was ordered for resident # 2 on 3/3/11. **How the facility will act to protect residents in similar situations:** The Social Service Director interviewed all residents who require the mechanical lift to ensure that they have been able to get up when they want to, and that there haven't been any issues due to slings on 3/3/11. The Social Service Director interviewed all alert and oriented residents to ensure that they have been able to use their call light due to it being within their reach on 3/3/11. No problems were found. **Measures to prevent reoccurrence:** We ordered 10 slings on 2/11/11. The DON/Staff Development Coordinator will in-service all nursing staff on the new sling protocol by 3/11/11. We numbered each sling and assigned each resident who required the use of the mechanical lift a sling. Maintenance placed a hook in each resident's closet on 2/25/11 and the slings will be placed there when not in use. Laundry will place the other slings in the clean utility room for them to use for showers. A breathe call cord was ordered on 3/3/11 for resident #2. The DON/Staff Development Coordinator will educate resident #2 on the use of the breathe call cord when it comes in. The DON/ADON will interview 20% of the residents who require the lift monthly to ensure they are able to get up when they want. The DON/ADON will interview 20% of the residents including resident #5 to ensure they are able to use their call light.	

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F 246	Continued From page 4 days he/she gets a bath, related to the facility not having enough slings for mechanical lifts. Resident #5 stated during the bath the sling for the lift became wet, and the staff did not have a dry sling to get the resident up into a chair. The resident stated on bath days he/she does not get up out of bed except to get a shower. An interview conducted with Certified Nursing Assistant (CNA) #1 on February 9, 2011, at 2:45 p.m., revealed there have been multiple occasions when resident #5 had not gotten out of bed related to not having a dry sling to get the resident up with. CNA #1 stated further the resident required a mechanical lift in order to get the resident out of bed, and if the sling got wet, the facility did not have enough slings to get all the residents up which require slings. An interview conducted with CNA #2 on February 9, 2011, at 3:00 p.m., revealed the CNA stated the facility does not have enough slings. The CNA further stated on shower days the residents requiring slings were only gotten up for showers, because the slings were wet, and there were not enough dry slings for all the residents. The CNA stated this happened on a daily basis. The CNA further stated resident #5 had not been gotten up in a chair on this date because the resident had a shower, and there was no available sling to get the resident up into the wheelchair. The CNA further revealed on bath days the resident would require two slings in order to get up after the shower, one sling for the shower and one additional dry sling to get the resident up in a chair. An interview conducted with CNA #6 on February 9, 2011, at 2:30 p.m., revealed the facility does	F 246	**Monitoring of Corrective Action:** The findings from the resident interviews ensuring the residents are able to get up with the mechanical lift and interviews ensuring residents are able to use their call light will be reviewed by the Quality Assurance Committee monthly for 6 months, for recommendations and further follow-up as indicated **Completion date: 3/18/11**	

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F 246	Continued From page 5 not have enough slings for the mechanical lift. The CNA stated the facility runs out of dry slings a lot. The CNA further revealed when the resident gets a shower the resident does not get up after the shower because the sling would be wet, and there were usually no other slings available. An interview conducted with the Director of Nursing (DON) for the facility on February 9, 2011, at 5:35 p.m., revealed the DON had been unaware of any resident who had not gotten out of bed related to a sling not being available. The DON further stated he/she felt the facility had enough slings to ensure the residents were able to get out of bed. The DON further stated if a sling was wet, the CNA was expected to take the sling to the laundry to be washed and dried, before the sling was returned to the floor. A list of 15 residents requiring a mechanical lift to get out of bed was provided by the facility; however, the facility could only find 16 slings. An interview conducted with resident #5 on February 9, 2011, at 1:50 p.m., revealed the resident used a headset for the telephone for approximately six to seven hours daily. The resident stated during the time he/she has the headset the resident was unable to use the call light due to requiring a touch call light which would be placed under the resident's chin. The resident stated he/she must call out to the staff passing in the hallway to summon help while using the headset. The resident further stated the staff came in to check on the resident no more frequently than when the resident has the call light in place.	F 246		

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F 246	Continued From page 6 An interview conducted with CNA #1 on February 9, 2011, at 2:45 p.m., revealed the CNA stated resident #5 used the telephone with the headset most of the afternoon every day. The CNA stated during the time the resident was using the headset the resident was unable to use the call light, and must vocally call the staff in the hallway as they go by. The CNA further stated he/she did not check on the resident any more frequently during this time even though the resident was unable to access the call light system. An interview conducted with CNA #2 on February 9, 2011, at 3:00 p.m., revealed the CNA stated resident #5 was unable to use his/her call light when using the telephone headset and the resident uses the headset most of the afternoon. The CNA further stated the resident "hollers when he/she needs something to whoever is in the hallway." However the CNA further revealed the resident has in the past had to call his/her family to call the facility to alert them of the resident requiring staff assistance. An interview with the DON of the facility on February 9, 2011, at 5:35 p.m., revealed the DON had not been aware of the problem of the resident not being able to use the call light when using the telephone.	F 246		